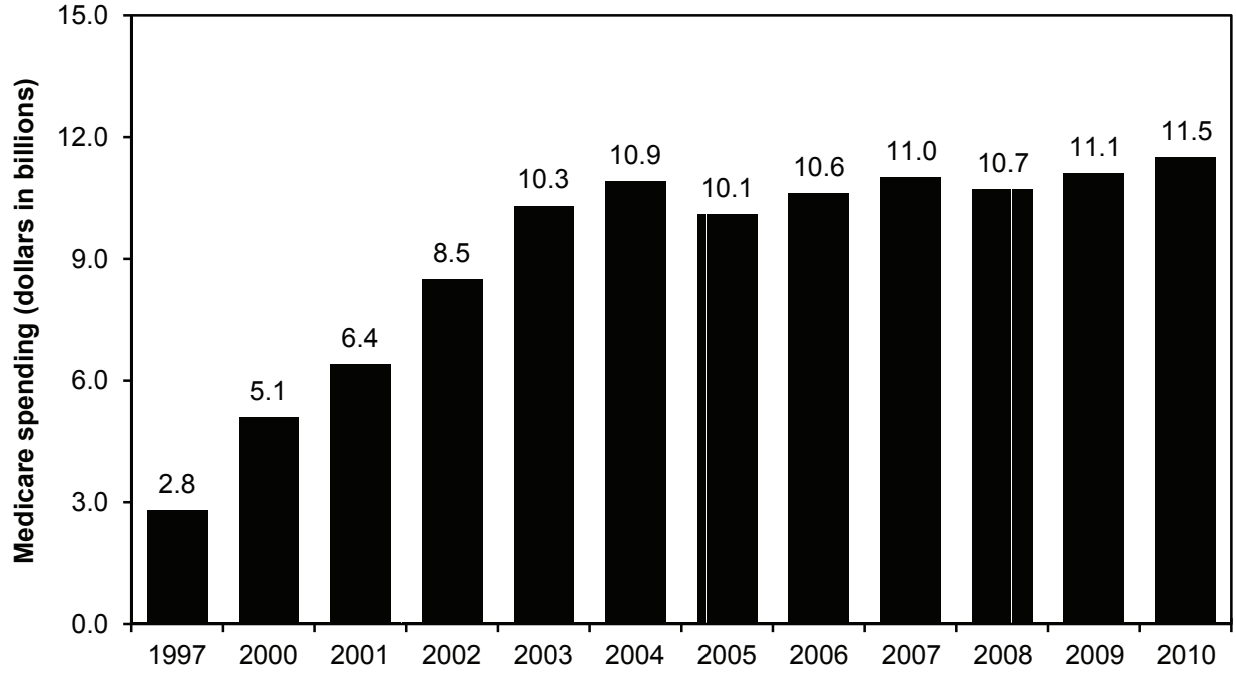
SECTION 10

Prescription drugs

Chart 10-1. Medicare spending for Part B drugs administered in physicians' offices or furnished by suppliers



Note: Data include Part B–covered drugs administered in physicians' offices or furnished by suppliers (e.g., certain oral drugs and drugs used with durable medical equipment). Data do not include Part B–covered drugs furnished in hospital outpatient departments or dialysis facilities.

Source: MedPAC analysis of Medicare claims data.

- Spending for Part B drugs administered in physicians' offices or furnished by suppliers totaled about $11.5 billion in 2010, up 4.3 percent from the 2009 level.

- Medicare spending on Part B drugs increased at an average rate of 25 percent per year from 1997 to 2003. In 2005, the Medicare payment rate changed from one based on the average wholesale price to 106 percent of the average sales price. With the move to the new payment system, spending declined 8 percent in 2005. Since then, spending has increased modestly, growing at an average rate of 2.7 percent per year since 2005.

- In addition to the new payment system, another factor contributing to slower growth in Part B drug spending is reduced use of darbepoetin alfa and epoetin alfa. Annual Part B spending on these products declined by more than $1 billion between 2005 and 2010 as use of these products decreased in response to changes in Food and Drug Administration labeling and CMS coverage policy. Excluding these two products, Part B drug spending has grown at an average rate of 5.4 per year since 2005.

- This total does not include drugs provided through outpatient departments of hospitals or to patients with end-stage renal disease in dialysis facilities. MedPAC estimates that payments (including cost sharing) for separately billed drugs provided in hospital outpatient departments equaled about $4.1 billion in 2010. We estimate that freestanding and hospital-based dialysis facilities billed Medicare an additional $3.0 billion for drugs in 2010.

Chart 10-2. Top 10 Part B drugs administered in physicians' offices or furnished by suppliers, by share of expenditures, 2010

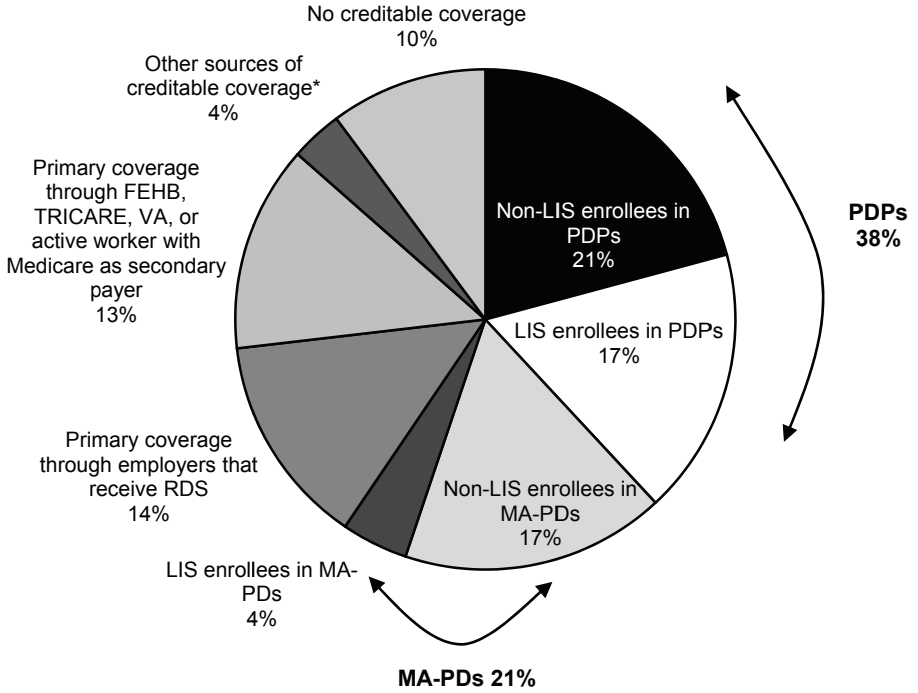
Drug name	Clinical indications	Allowed Charges (in millions)	Competition	Percent of spending	Rank in 2009
Ranibizumab	Age-related macular degeneration	$1,119	Sole source	9.7%	2
Rituximab	Lymphoma, leukemia, rheumatoid arthritis	$849	Sole source	7.4	1
Bevacizumab	Cancer, age-related macular degeneration	$766	Sole source	6.6	3
Infliximab	Rheumatoid arthritis, Crohn's disease	$647	Sole source	5.6	4
Pegfilgrastim	Cancer	$553	Sole source	4.8	5
Darbepoetin alfa	Anemia	$374	Sole source	3.2	6
Epoetin alfa	Anemia	$327	Multisource biologic	2.8	7
Pemetrexed	Lung cancer	$276	Sole source	2.4	not listed
Docetaxel	Cancer	$269	Sole source*	2.3	9
Tacrolimus	Prevent organ transplant rejection	$259	Multisource	2.2	10

Note: Data do not include Part B drugs furnished in hospital outpatient departments or dialysis facilities. Allowed charges include Medicare program payments and beneficiary cost-sharing. Clinical indications may include on- and off-label use. *Docetaxel was sole source in 2009, but generic versions have since become available.

Source: MedPAC analysis of Medicare claims data from CMS and information on drug and biologic approval information from the Food and Drug Administration website (http://www.fda.gov).

- Medicare covers approximately 600 outpatient drugs under Part B, but spending is very concentrated. The top 10 drugs account for about 47 percent of all Part B drug spending.
- Ranibizumab, a biologic for age-related macular degeneration, was the Part B drug with the greatest Medicare expenditures in 2010, exceeding $1.1 billion.
- The seven highest expenditure products are biologics.
- Treatment for cancer dominates the list (7 of the top 10 drugs treat cancer or the side effects associated with chemotherapy) because most cancer drugs must be administered by physicians, a requirement for coverage of most Part B drugs.
- Data reflect Part B drugs administered in physicians' offices or furnished by suppliers.

Chart 10-3. In 2010, about 90 percent of Medicare beneficiaries were enrolled in Part D plans or had other sources of creditable drug coverage



Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), RDS (retiree drug subsidy), FEHB (Federal Employees Health Benefits program), VA (Department of Veterans Affairs). TRICARE is the health program for military retirees and their dependents.
*Creditable coverage means drug benefits whose value is equal to or greater than that of the basic Part D benefit.

Source: CMS Management Information Integrated Repository, February 16, 2010; Office of Personnel Management; Department of Defense; Department of Veterans Affairs; CMS Coordination of Benefits Database; CMS Creditable Coverage Database.

- As of February 2010, CMS estimated that 34 million of the 46 million Medicare beneficiaries (73 percent) were either signed up for Part D plans or had prescription drug coverage through employer-sponsored plans under Medicare's RDS. (If an employer agrees to provide primary drug coverage to its retirees with an average benefit value that is equal to or greater in value than that of Part D (called creditable coverage), Medicare provides the employer with a tax-free subsidy for 28 percent of each eligible individual's drug costs that fall within a specified range of spending.)

- About 10 million beneficiaries (nearly 22 percent) receive Part D's LIS. Of these individuals, 6.4 million are dually eligible to receive Medicare and all Medicaid benefits offered in their state. Another 3.5 million qualified for extra help either because they receive benefits through the Medicare Savings Program or Supplemental Security Income Program or because they applied directly to the Social Security Administration. Among all LIS beneficiaries, about 8 million (17 percent of all Medicare beneficiaries) are enrolled in stand-alone PDPs and 2 million (4 percent) are in MA–PD plans.

(Chart continued next page)

Chart 10-3. In 2010, about 90 percent of Medicare beneficiaries were enrolled in Part D plans or had other sources of creditable drug coverage (continued)

- Other enrollees in stand-alone PDPs numbered 9.7 million, or 21 percent of all Medicare beneficiaries. Another 7.9 million enrollees (17 percent) are in MA–PD plans or other private Medicare health plans. Individuals whose employers receive Medicare's RDS numbered 6.4 million, or 14 percent. Those groups of beneficiaries directly affect Medicare program spending.

- Other Medicare beneficiaries have creditable drug coverage, but that coverage does not affect Medicare program spending. For example, 6.2 million beneficiaries (13 percent) receive drug coverage through the FEHB, TRICARE, VA, or current employers because the individual is still an active worker. CMS estimates that another 1.6 million individuals have other sources of creditable coverage.

- An estimated 4.7 million beneficiaries (10 percent) have no creditable drug coverage.

Chart 10-4. Parameters of the defined standard benefit increase over time

	2006	2009	2010	2011	2012
Deductible	$250.00	$295.00	$310.00	$310.00	$320.00
Initial coverage limit	2,250.00	2,700.00	2,830.00	2,840.00	2,930.00
Annual out-of-pocket threshold	3,600.00	4,350.00	4,550.00	4,550.00	4,700.00
Total covered drug spending at annual out-of-pocket threshold	5,100.00	6,153.75	6,440.00	6,447.50	6,657.50
Maximum amount of cost sharing in the coverage gap	2,850.00	3,453.75	3,610.00	3,607.50	3,727.50
Minimum cost sharing above the annual out-of-pocket threshold					
Copay for generic/preferred multisource drug	2.00	2.40	2.50	2.50	2.60
Copay for other prescription drugs	5.00	6.00	6.30	6.30	6.50

Note: Under Part D's defined standard benefit, the enrollee pays the deductible and then 25 percent of covered drug spending (75 percent paid by the plan) until total covered drug spending reaches the initial coverage limit (ICL). Before 2011, enrollees exceeding the ICL were responsible for paying 100 percent of covered drug spending up to the annual out-of-pocket threshold. Beginning in 2011, enrollees face reduced cost sharing in the coverage gap. The amount for 2012 ($6,657.50) is for an individual with no other sources of supplemental coverage filling only brand-name drugs during the coverage gap. Cost sharing paid by most sources of supplemental coverage does not count toward this threshold. The enrollee pays nominal cost sharing above the limit.

Source: CMS, Office of the Actuary.

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 specified a defined standard benefit structure. In 2012, it has a $320 deductible, 25 percent coinsurance on covered drugs until the enrollee reaches $2,930 in total covered drug spending, and then a coverage gap until annual out-of-pocket spending reaches the annual threshold. Before 2011, enrollees were responsible for paying the full discounted price of covered drugs filled during the coverage gap. Because of changes made by the Patient Protection and Affordable Care Act of 2010, enrollees face reduced cost sharing for drugs filled in the coverage gap. In 2012, the cost sharing for drugs filled during the gap phase is 50 percent for brand-name drugs and 86 percent for generic drugs. Enrollees with drug spending that exceeds the annual threshold would pay the greater of $2.60 to $6.50 per prescription or 5 percent coinsurance.

- The parameters of this defined standard benefit structure increase over time at the same rate as the annual increase in average total drug expenses of Medicare beneficiaries.

- Within certain limits, sponsoring organizations may offer Part D plans that have the same actuarial value as the defined standard benefit, but a different benefit structure. For example, a plan may use tiered copayments rather than 25 percent coinsurance. Or a plan may have no deductible, but use cost-sharing requirements that are equivalent to a rate higher than 25 percent. Both defined standard benefit plans and plans that are actuarially equivalent to the defined standard benefit are known as "basic benefits."

- Once a sponsoring organization offers one plan with basic benefits within a prescription drug plan region, it may also offer a plan with enhanced benefits—basic and supplemental coverage combined.

Chart 10-5. Characteristics of Medicare PDPs

	2011				2012			
	Plans		Enrollees as of February 2011		Plans		Enrollees as of February 2012	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	1,109	100%	17.0	100%	1,041	100%	17.5	100%
Type of organization								
National[a]	851	77	13.9	82	838	80	14.9	85
Other	258	23	3.0	18	203	20	2.6	15
Type of benefit								
Defined standard	133	12	1.3	8	95	9	1.0	5
Actuarially equivalent[b]	474	43	12.6	74	446	43	13.2	75
Enhanced	502	45	3.0	18	500	48	3.3	19
Type of deductible								
Zero	464	42	7.3	43	488	47	7.3	42
Reduced	197	18	2.1	13	108	10	1.8	11
Defined standard[c]	448	40	7.6	45	445	43	8.3	48
Drugs covered in the gap								
Some generics but no brand-name drugs	259	23	2.2	13	197	19	0.8	4
Some generics and some brand-name drugs	106	10	0.3	2	73	7	0.3	2
None	744	67	14.4	85	771	74	16.4	94

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Excluded plans have 2 million enrollees in 2012 and had 1.6 million in 2011. Sums may not add to totals due to rounding.
[a] Reflects total numbers of plans for organizations with at least 1 PDP in each of the 34 PDP regions.
[b] Includes "actuarially equivalent standard" and "basic alternative" benefits.
[c] $310 in 2011 and $320 in 2012.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

- Part D drew about 6 percent fewer stand-alone PDPs into the field for 2012 than in 2011. Plan sponsors are offering 1,041 PDPs in 2012 compared with 1,109 in 2011.
- In 2012, 80 percent of all PDPs are offered by sponsoring organizations that have at least 1 PDP in each of the 34 PDP regions. Plans offered by those national sponsors account for 85 percent of all PDP enrollment.
- Sponsors are offering about the same number of PDPs with enhanced benefits (basic plus supplemental coverage) for 2012 and fewer PDPs with actuarially equivalent benefits—having the same average value as the defined standard benefit, but with alternative benefit designs. Most enrollees (75 percent) are in actuarially equivalent plans.
- A smaller proportion of PDPs include some benefits in the coverage gap for 2012 than in 2011. About 27 percent of all plans with some gap coverage offer generics and brand-name drugs, compared with about a third in 2011.
- In 2012, 94 percent of PDP enrollees are in plans that offer no additional benefits in the coverage gap. However, because of the changes made by the Patient Protection and Affordable Care Act of 2010, beginning in 2011, beneficiaries no longer face 100 percent coinsurance in the coverage gap (see Chart 10-4). In addition, many PDP enrollees receive Part D's low-income subsidy, which effectively eliminates the coverage gap.

Chart 10-6. Characteristics of MA–PDs

	2011				2012			
	Plans		Enrollees as of February 2011		Plans		Enrollees as of February 2012	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Totals	1,506	100%	8.6	100%	1,541	100%	8.5	100%
Type of organization								
Local HMO	909	60	5.7	66	951	62	5.9	69
Local PPO	421	28	1.7	20	430	28	1.5	18
PFFS	137	9	0.5	5	125	8	0.4	5
Regional PPO	39	3	0.7	8	35	2	0.7	8
Type of benefit								
Defined standard	42	3	0.1	1	37	2	0.1	1
Actuarially equivalent*	108	7	0.6	7	86	6	0.5	6
Enhanced	1,356	90	7.9	92	1,418	92	7.9	94
Type of deductible								
Zero	1,320	88	7.8	91	1,372	89	7.5	88
Reduced	110	7	0.5	6	98	6	0.8	9
Defined standard**	76	5	0.2	3	71	5	0.2	2
Drugs covered in the gap								
Some generics but no brand-name drugs	441	29	3.0	36	373	24	2.1	25
Some generics and some brand-name drugs	350	23	1.6	19	397	26	2.3	27
None	715	47	3.9	46	771	50	4.0	48

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). The MA–PD plans and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Sums may not add to totals due to rounding. In previous years, we have treated different segments of an MA–PD as separate plans for the purpose of reporting the number of plans available. The figures shown above no longer distinguish between different segments of a plan.
*Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.
**$310 in 2011 and $320 in 2012.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

- There are slightly more MA–PD plans in 2012 than in 2011. Sponsors are offering 1,541 MA–PD plans compared with 1,506 the year before (about 2 percent more). HMOs remain the dominant kind of MA–PD plans, making up 62 percent of all (unweighted) offerings in 2012. The number of PFFS plans continues to decline, from 137 in 2011 to 125 in 2012. The number of drug plans offered by both local and regional preferred provider organizations decreased slightly between 2011 and 2012.
- A larger share of MA–PD plans than stand-alone prescription drug plans (PDPs) offer enhanced benefits (compare Chart 10-6 with Chart 10-5). In 2012, 48 percent of all PDPs had enhanced benefits compared with 92 percent of MA–PD plans. In 2012, enhanced MA–PD plans attracted 94 percent of total MA–PD enrollment.
- Most MA–PD plans have no deductible: 89 percent of MA–PD offerings in 2012 and 88 percent in 2011. MA–PD plans with no deductible attracted about 88 percent of total MA–PD enrollment in 2012.
- MA–PD plans are more likely than PDPs to provide some additional benefits in the coverage gap. In 2012, 50 percent of MA–PD plans included some gap coverage—24 percent with some generics, but no brand-name drug coverage and 26 percent with some generics and some brand-name drug coverage. Those plans account for 52 percent of MA–PD enrollment.

Chart 10-7. Average Part D premiums

	2011 enrollment (in millions)	Average monthly 2011 premium weighted by 2011 enrollment	2012 enrollment (in millions)	Average monthly 2012 premium weighted by 2012 enrollment	Dollar change	Percentage change in weighted average premium
PDPs						
Basic coverage	13.9	$33	14.1	$33	$0	0%
Enhanced coverage	3.0	63	3.3	58	–4.5	–7
Any coverage	17.0	38	17.5	38	–0.6	–1
MA–PDs, including SNPs*						
Basic coverage	1.1	27	1.3	27	–0.1	–1
Enhanced coverage	7.5	12	8.0	12	0.1	1
Any coverage	8.6	14	9.3	14	0.3	2
All plans						
Basic coverage	15.0	33	15.5	33	–0.1	0
Enhanced coverage	10.6	26	11.3	26	–1.0	–4
Any coverage	25.5	30	26.8	30	–0.5	–2

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNPs (special needs plans). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. The MA–PD plans and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, demonstrations, and Part B-only plans.
*Reflects the portion of Medicare Advantage plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage. MA–PD premiums reflect rebate dollars (between 67 percent and 73 percent of the difference between a plan's payment benchmark and its bid for providing Part A and Part B services in 2012) that were used to offset Part D premium costs. Lower average premiums for enhanced MA–PD plans reflect a different mix of sponsoring organizations and counties of operation than MA–PD plans with basic coverage.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

- The average premium paid by Part D enrollees remained stable at around $30 per month in 2012.
- The average premiums for beneficiaries enrolled in PDP remained flat in 2012 at $38 per month, a decrease of less than $1.
- MA–PD plans can lower the part of their monthly premium attributable to Part D using rebate dollars—a portion (between 67 percent and 73 percent in 2012) of the difference between the plan's payment benchmark and its bid for providing Part A and Part B services. MA–PD plans may also enhance their Part D benefit with rebate dollars. Many MA–PD plans use rebate dollars in these ways, resulting in more enhanced offerings and lower average premiums compared with PDPs.
- The portion of Medicare Advantage premiums attributable to prescription drug benefits remained flat (increase of less than $1) in 2012, with the average MA–PD enrollee paying $14 per month.

Chart 10-8. Number of PDPs qualifying as premium-free to LIS enrollees remained stable in 2012

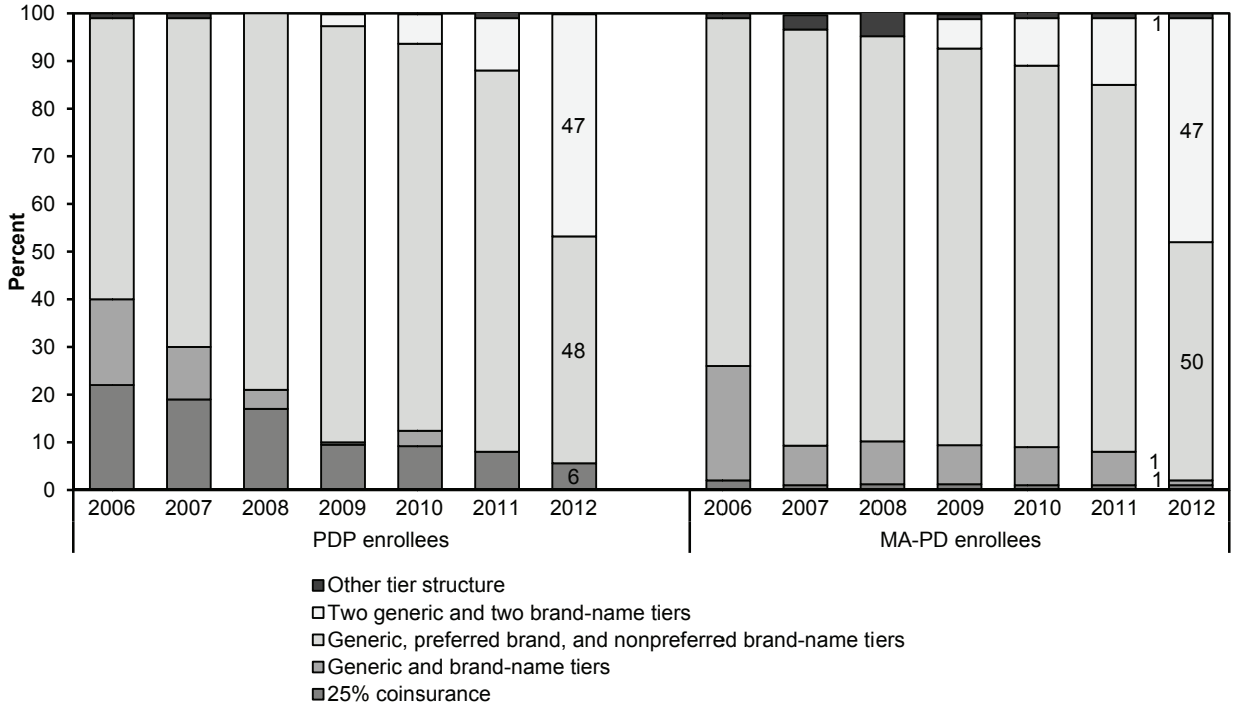
PDP region	State(s)	Number of PDPs			Number of PDPs that have zero premium for LIS enrollees		
		2011	2012	Difference	2011	2012	Difference
1	ME, NH	30	28	–2	7	8	1
2	CT, MA, RI, VT	34	30	–4	12	10	–2
3	NY	33	29	–4	11	12	1
4	NJ	33	30	–3	6	9	3
5	DC, DE, MD	33	31	–2	12	13	1
6	PA, WV	38	36	–2	12	12	0
7	VA	32	30	–2	10	10	0
8	NC	33	30	–3	11	9	–2
9	SC	34	32	–2	15	12	–3
10	GA	32	30	–2	14	12	–2
11	FL	32	33	1	4	3	–1
12	AL, TN	34	32	–2	11	12	1
13	MI	35	34	–1	12	12	0
14	OH	34	33	–1	8	8	0
15	IN, KY	32	31	–1	14	13	–1
16	WI	32	29	–3	10	10	0
17	IL	35	33	–2	10	10	0
18	MO	32	30	–2	5	8	3
19	AR	34	30	–4	17	15	–2
20	MS	32	30	–2	14	12	–2
21	LA	32	30	–2	10	12	2
22	TX	33	33	0	12	13	1
23	OK	33	30	–3	10	9	–1
24	KS	33	31	–2	12	10	–2
25	IA, MN, MT, ND, NE, SD, WY	33	33	0	10	9	–1
26	NM	32	30	–2	8	6	–2
27	CO	31	28	–3	7	5	–2
28	AZ	30	30	0	9	10	1
29	NV	31	29	–2	4	2	–2
30	OR, WA	32	30	–2	8	9	1
31	ID, UT	35	33	–2	11	12	1
32	CA	33	33	0	5	6	1
33	HI	28	25	–3	6	10	4
34	AK	29	25	–4	5	4	–1
	Total	1,109	1,041	–68	332	327	–5

Note: PDP (prescription drug plan), LIS (low-income subsidy).

Source: MedPAC based on 2012 PDP landscape file provided by CMS.

- The number of stand-alone PDPs decreased by 6 percent around the country, from 1,109 in 2011 to 1,041 in 2012. The median number of plans offered in each region in 2012 is 30 compared with 33 in 2011.
- Hawaii and Alaska had the fewest stand-alone PDPs with 25; the Pennsylvania–West Virginia region had the most with 36.
- In 2012, enrollees who receive Part D's LIS have about the same number of options for PDPs in which they pay no premium. In 2012, 327 PDPs qualified to be premium-free to those enrollees, compared with 332 in 2011.
- Each region has at least two PDPs available to LIS enrollees at no premium; most regions have substantially more zero premium plans available.

Chart 10-9. In 2012, most Part D enrollees are in plans that charge higher copayments for nonpreferred brand-name drugs



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Calculations are weighted by enrollment. All calculations exclude employer-only groups and plans offered in U.S. territories. In addition, MA–PD plans exclude demonstration programs, special needs plans, and 1876 cost plans. Sums may not add to totals due to rounding.

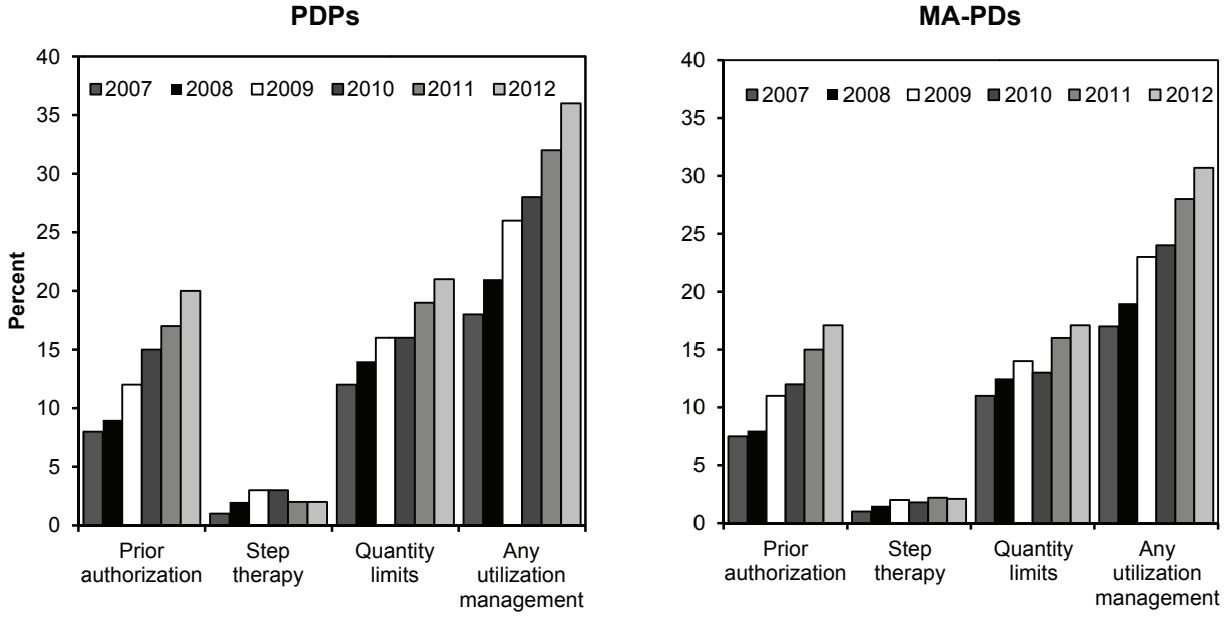
Source: MedPAC-sponsored analysis by NORC/Georgetown University/Social and Scientific Systems analysis of formularies submitted to CMS.

- In 2012, 48 percent of PDP enrollees are in plans that distinguish between preferred and nonpreferred brand-name drugs; another 47 percent are in plans with two generic and two brand-name tiers. In 2006, only 59 percent of PDP enrollees were in plans with such distinctions. Nearly all (97 percent) MA–PD enrollees are in such plans in 2012, up from 73 percent in 2006.

- For enrollees in PDPs that distinguish between preferred and nonpreferred brand-name drugs, the median copay in 2012 is $41 for a preferred brand and $93 for a nonpreferred brand. The median copay for generic drugs is $5. For MA–PD enrollees, in 2012, the median copay is $42 for a preferred brand, $84 for a nonpreferred brand, and $6 for a generic drug.

- Most plans, except those that use the defined standard benefit's 25 percent coinsurance for all drugs, also use a specialty tier for drugs that have a negotiated price of $600 per month or more. In 2012, median cost sharing for a specialty tier drug is 30 percent among PDPs and 33 percent among MA–PD plans. Enrollees may not appeal cost sharing for drugs in specialty tiers.

Chart 10-10. In 2012, use of utilization management tools continues to increase for both PDPs and MA–PDs



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Calculations are weighted by enrollment. All calculations exclude employer-only groups and plans offered in U.S. territories. In addition, MA–PD plans exclude demonstration programs, special needs plans, and 1876 cost plans. Values reflect the percent of listed chemical entities that are subject to utilization management, weighted by plan enrollment. Prior authorization means that the enrollee must get preapproval from the plan before coverage. Step therapy refers to a requirement that the enrollee try specified drugs first before moving to other drugs. Quantity limits mean that plans limit the number of doses of a drug available to the enrollee in a given time period.

Source: MedPAC-sponsored analysis by NORC/Georgetown University/Social and Scientific Systems analysis of formularies submitted to CMS.

- The number of drugs listed on a plan's formulary does not necessarily represent beneficiary access to medications. Plans' processes for nonformulary exceptions, prior authorization (preapproval from plan before coverage), quantity limits (plans limit the number of doses of a particular drug covered in a given time period), and step therapy requirements (enrollees must try specified drugs before moving to other drugs) can affect access to certain drugs. For example, unlisted drugs may be covered through the nonformulary exceptions process, which may be relatively easy for some plans and more burdensome for others. Alternatively, on-formulary drugs may not be covered in cases in which a plan does not approve a prior authorization request. Also, a formulary's size can be deceptively large if it includes drugs that are no longer used in common practice.

- In 2012, the average enrollee in a stand-alone prescription drug plan faces some form of utilization management for 36 percent of drugs listed on a plan's formulary, compared with 31 percent for the average MA–PD plan enrollee. Part D plans typically use quantity limits or prior authorization to manage enrollees' prescription drug use.

Chart 10-11. Characteristics of Part D enrollees, 2010

	All Medicare	Part D	Plan type		Subsidy status	
			PDP	MA–PD	LIS	Non-LIS
Beneficiaries[a] (in millions)	49.9	29.7	18.9	10.6	11.3	18.4
Percent of all Medicare	100%	60%	38%	21%	23%	37%
Gender						
Male	45%	41%	40%	43%	39%	43%
Female	55	59	60	57	61	57
Race/ethnicity						
White, non-Hispanic	77	74	76	71	58	84
African American, non-Hispanic	10	11	11	11	20	6
Hispanic	8	10	8	14	15	7
Asian	3	3	3	3	5	2
Other	2	2	2	1	2	1
Age (years)						
<65	22	23	27	17	42	12
65–69	24	22	20	26	14	27
70–74	18	18	17	20	13	21
75–79	14	14	13	16	11	16
80+	22	22	23	21	20	24
Urbanicity[b]						
Metropolitan	78	79	74	88	77	80
Micropolitan	12	12	15	7	13	11
Rural	8	9	11	4	10	8
Average risk score[c]	1.062	1.117	1.137	1.083	1.217	1.055
Percent relative to all Part D		100%	102%	97%	109%	94%

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). Totals may not sum to 100 percent due to rounding.
[a] Figures for Medicare and Part D include all beneficiaries with at least one month of enrollment in the respective program. A beneficiary is classified as LIS if that individual received Part D's LIS at some point during the year. For individuals who switch plan types during the year, classification into plan types is based on a greater number of months of enrollment. About 200,000 enrollees could not be classified into a plan type due to missing data.
[b] Urbanicity based on the Office of Management and Budget's core-based statistical area. A metropolitan area contains a core urban area of 50,000 or more population, and a micropolitan area contains an urban core of at least 10,000 (but less than 50,000) population. About 1 percent of Medicare beneficiaries were excluded due to an unidentifiable core-based statistical area designation.
[c] Part D risk scores are calculated by CMS using the prescription drug hierarchical condition category model developed before 2006. Risk scores shown here are not adjusted for LIS or institutionalized status (multipliers).

Source: MedPAC analysis of Medicare Part D denominator and Risk Adjustment System files from CMS.

- In 2010, 29.7 million Medicare beneficiaries (60 percent) enrolled in Part D at some point in the year. Most of them (18.9 million) were in stand-alone PDPs, with 10.6 million in MA–PD plans. A little over 11 million enrollees received Part D's LIS.

(Chart continued next page)

Chart 10-11. Characteristics of Part D enrollees, 2010 (continued)

- Compared with the overall Medicare population, Part D enrollees are more likely to be female and non-White. MA–PD enrollees are less likely to be disabled beneficiaries under age 65 and more likely to be Hispanic compared with PDP enrollees; LIS enrollees are more likely to be female, non-White, and disabled beneficiaries under age 65 compared with non-LIS enrollees.
- Patterns of enrollment by urbanicity for Part D enrollees were similar to the overall Medicare population with 79 percent in metropolitan areas, 12 percent in micropolitan areas, and the remaining 9 percent in rural areas.
- The average risk score for PDP enrollees is higher (1.137) than the average for all Part D enrollees (1.117), while the average risk score for MA–PD enrollees is lower (1.083).

Chart 10-12. Part D enrollment trends, 2006–2010

	2006	2007	2008	2009	2010
Part D enrollment, in millions*					
Total	24.5	26.1	27.5	28.7	29.7
By plan type					
PDP	17.7	18.3	18.6	18.7	18.9
MA–PD	6.8	7.8	8.9	10.0	10.6
By subsidy status					
LIS	10.2	10.4	10.7	10.9	11.3
Non-LIS	14.3	15.7	16.9	17.8	18.4
By race/ethnicity					
White, non-Hispanic	17.2	19.4	20.5	21.4	22.0
African American, non-Hispanic	2.6	2.9	3.1	3.2	3.3
Hispanic	2.2	2.5	2.7	2.8	3.0
Other	2.5	1.3	1.3	1.3	1.4
By age (years)					
<65	5.6	6.1	6.4	6.6	6.9
65–69	5.0	5.4	5.9	6.3	6.6
70-79	8.3	8.7	9.0	9.3	9.6
80+	5.6	6.0	6.3	6.4	6.6
Enrollment growth, in percent					
Total	—	7%	5%	4%	4%
By plan type					
PDP	—	4	2	<1	1
MA–PD	—	14	14	12	6
By subsidy status					
LIS	—	2	2	2	4
Non-LIS	—	10	8	6	3
By race/ethnicity					
White, non-Hispanic	—	13	5	4	3
African American, non-Hispanic	—	13	5	4	4
Hispanic	—	14	6	6	6
Other	—	–49	6	<1	6
By age (years)					
<65	—	8	6	4	4
65–69	—	8	8	7	5
70–79	—	5	4	4	3
80+	—	7	4	3	2

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy).
*Figures include all beneficiaries with at least one month of enrollment. A beneficiary is classified as LIS if that individual received Part D's LIS at some point during the year. If a beneficiary was enrolled in both a PDP and an MA–PD plan during the year, that individual was classified into the type of plan with a greater number of months of enrollment. About 200,000 enrollees could not be classified into a plan type due to missing data. Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Part D denominator file from CMS.

- Between 2006 and 2010, MA–PD plan enrollment grew faster (by more than 10 percent per year between 2006 and 2009, and by 6 percent between 2009 and 2010) compared with growth rates of less than 5 percent per year for prescription drug plans. The number of enrollees receiving the LIS remained relatively flat between 2006 and 2009, while the number of non-LIS enrollees grew by 10 percent in 2007, 8 percent in 2008, and 6 percent in 2009. The growth in the number of LIS and non-LIS enrollees was 3 percent and 4 percent, respectively, between 2009 and 2010.

Chart 10-13. Part D enrollment by region, 2010

PDP region	State(s)	Percent of Medicare enrollment		Percent of Part D enrollment			
				Plan type		Subsidy status	
		Part D	RDS	PDP	MA–PD	LIS	Non-LIS
1	ME, NH	56%	12%	85%	15%	49%	51%
2	CT, MA, RI, VT	59	18	69	31	43	57
3	NY	60	18	55	45	46	54
4	NJ	53	22	81	19	35	65
5	DE, DC, MD	47	17	86	14	41	59
6	PA, WV	63	13	56	44	33	67
7	VA	53	10	78	22	37	63
8	NC	60	16	75	25	43	57
9	SC	55	16	77	23	45	55
10	GA	61	10	69	31	43	57
11	FL	61	13	53	47	35	65
12	AL, TN	61	13	65	35	47	53
13	MI	48	31	73	27	40	60
14	OH	55	23	63	37	36	64
15	IN, KY	60	14	80	20	39	61
16	WI	55	15	63	37	33	67
17	IL	56	19	87	13	38	62
18	MO	63	11	69	31	35	65
19	AR	61	9	80	20	45	55
20	MS	65	6	88	12	54	46
21	LA	62	13	65	35	49	51
22	TX	57	15	69	31	45	55
23	OK	60	8	79	21	38	62
24	KS	63	7	85	15	29	71
25	IA, MN, MT, NE, ND, SD, WY	66	9	73	27	27	73
26	NM	62	8	62	38	39	61
27	CO	59	13	49	51	29	71
28	AZ	61	12	45	55	32	68
29	NV	56	13	48	52	29	71
30	OR, WA	59	11	59	41	31	69
31	ID, UT	58	10	56	44	28	72
32	CA	70	9	51	49	39	61
33	HI	66	4	44	56	29	71
34	AK	39	26	99	1	62	38
	Mean	60	14	64	36	38	62
	Minimum	39	4	44	1	27	38
	Maximum	70	31	99	56	62	73

Note: PDP (prescription drug plan), RDS (retiree drug subsidy), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). Definition of regions based on PDP regions used in Part D.

Source: MedPAC analysis of Part D enrollment data from CMS.

- Among Part D regions, in 2010, between 39 percent and 70 percent of all Medicare beneficiaries enrolled in Part D. Beneficiaries were more likely to enroll in Part D in regions where a low take-up rate for the RDS was observed. For example, in Region 32 (California) and Region 33 (Hawaii), the shares of Medicare beneficiaries enrolled in Part D were 70 percent and 66 percent, respectively. In these two regions, fewer than 10 percent of beneficiaries enrolled in employer-sponsored plans that received the RDS.

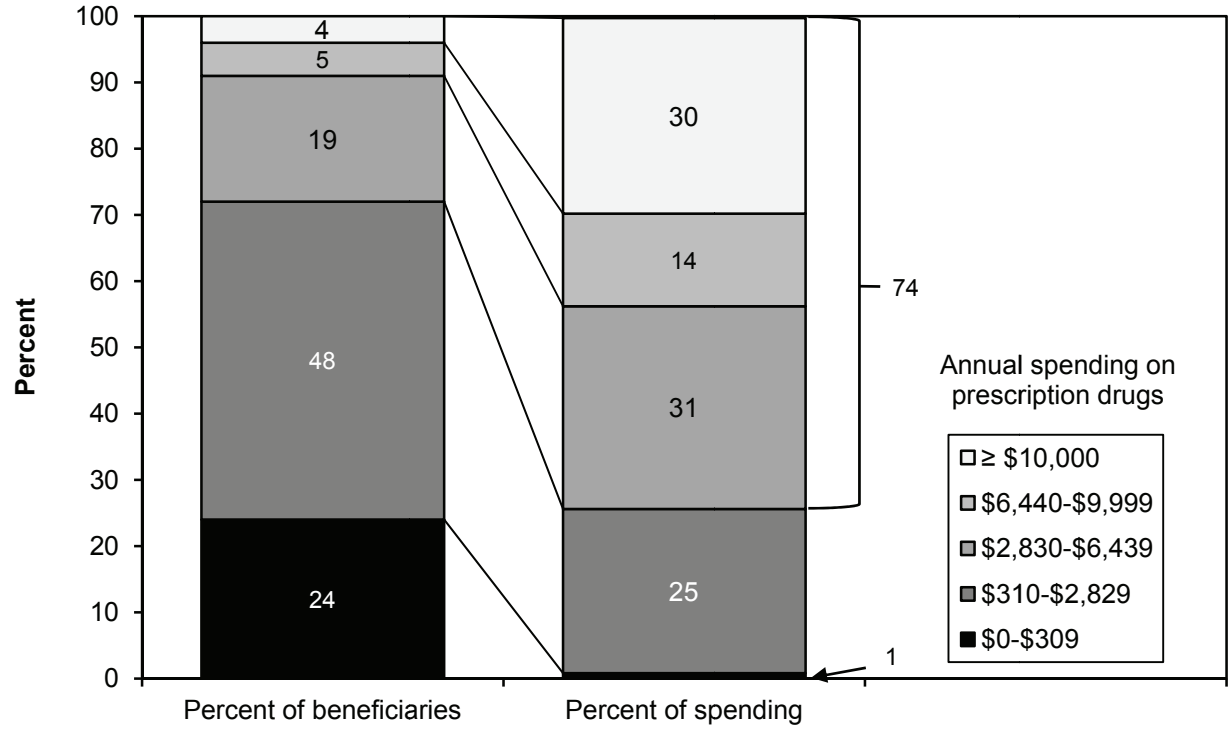
- A wide variation was seen in the shares of Part D enrollees who enrolled in PDPs and MA–PD plans across PDP regions. The pattern of MA–PD enrollment is generally consistent with enrollment in Medicare Advantage plans.

(Chart continued next page)

Chart 10-13. Part D enrollment by region, 2010 (continued)

- The share of Part D enrollees receiving the LIS ranged from 27 percent in Region 25 (Iowa, Minnesota, Montana, North Dakota, Nebraska, South Dakota, and Wyoming) to 62 percent in Region 34 (Alaska). In 26 of the 34 PDP regions, LIS enrollees account for 30 percent to 50 percent of enrollment. In two regions, Region 20 (Mississippi) and Region 34 (Alaska), LIS enrollees account for more than half of Part D enrollment.

Chart 10-14. The majority of Part D spending is incurred by fewer than half of all Part D enrollees, 2010



Note: Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Part D prescription drug event data from CMS.

- Medicare Part D spending is concentrated among a subset of beneficiaries. In 2010, 28 percent of Part D enrollees had annual spending of $2,830 or more, at which point enrollees were responsible for 100 percent of the cost of the drug until their spending reached $6,440 under the defined standard benefit. These beneficiaries accounted for 74 percent of total Part D spending.

- The costliest 9 percent of beneficiaries, those with drug spending above the catastrophic threshold under the defined standard benefit, accounted for 44 percent of total Part D spending. Slightly over three-quarters of beneficiaries with the highest spending receive Part D's low-income subsidy (see Chart 10-15). Spending on prescription drugs is less concentrated than Medicare Part A and Part B spending. In 2010, the costliest 5 percent of beneficiaries accounted for 38 percent of annual Medicare fee-for-service (FFS) spending, and the costliest quartile accounted for 81 percent of Medicare FFS spending

Chart 10-15. Characteristics of Part D enrollees, by spending levels, 2010

	Annual drug spending		
	<$2,830	$2,830–$6,440	>$6,440
Sex			
Male	42%	38%	39%
Female	58	62	61
Race/ethnicity			
White, non-Hispanic	74	75	71
African American, non-Hispanic	11	11	14
Hispanic	10	9	10
Other	5	5	5
Age (years)			
<65	21	22	44
65–69	24	19	14
70–74	19	18	13
75–80	14	15	11
80+	21	26	19
LIS status*			
LIS	31	46	77
Non-LIS	69	54	23
Plan type**			
PDP	61	70	80
MA–PD	39	30	20

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). A small number of beneficiaries were excluded from the analysis because of missing data. Totals may not sum to 100 percent due to rounding.
*A beneficiary is assigned LIS status if that individual received Part D's LIS at some point during the year.
**If a beneficiary was enrolled in both a PDP and an MA–PD plan during the year, that individual was classified in the type of plan with a greater number of months of enrollment.

Source: MedPAC analysis of Medicare Part D prescription drug events data and Part D denominator file from CMS.

- In 2010, beneficiaries with annual drug spending of more than $2,830 were more likely to be female than beneficiaries with annual spending below $2,830 (62 percent and 61 percent compared with 58 percent).

- Beneficiaries with annual spending greater than $6,440 are more likely to be disabled beneficiaries under age 65 and receive the LIS compared with those with annual spending below $2,830.

- Most beneficiaries with spending greater than $6,440 are enrolled in stand-alone PDPs (80 percent) compared with MA–PD plans (20 percent). On the other hand, beneficiaries with annual spending below $2,830 are more likely to be in MA–PDs compared with those with higher annual spending (39 percent compared with 20 percent). This finding reflects the fact that most LIS enrollees are more costly on average and are in PDPs.

Chart 10-16. Part D spending and utilization per enrollee, 2010

	Part D	Plan type		LIS status	
		PDP	MA–PD	LIS	Non-LIS
Total gross spending (billions)	$77.7	$56.7	$20.9	$43.3	$34.4
Total number of prescriptions[a] (millions)	1,406	944	462	629	777
Average spending per prescription	$55	$60	$45	$69	$44
Per enrollee per month					
Total spending	$231	$265	$172	$348	$163
Out-of-pocket spending[b]	40	41	37	8	59
Plan liability[c]	138	154	111	197	103
Low-income cost sharing subsidy	53	70	23	142	N/A
Number of prescriptions[a]	4.2	4.4	3.8	5.1	3.7

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy), N/A (not applicable). Part D prescription drug event (PDE) records are classified into plan types based on the contract identification on each record. For purposes of classifying the PDE records by LIS status, monthly LIS eligibility information in Part D's denominator file was used. Estimates are sensitive to the method used to classify PDE records to each plan type and LIS status. Numbers may not sum to totals due to rounding.
[a] Number of prescriptions standardized to a 30-day supply.
[b] Out-of-pocket (OOP) spending includes all payments that count toward the annual OOP spending threshold.
[c] Plan liability includes plan payments for drugs covered by both basic and supplemental (enhanced) benefits.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

- In 2010, gross spending on drugs for the Part D program totaled $77.7 billion, with roughly three-quarters ($56.7 billion) accounted for by Medicare beneficiaries enrolled in PDPs. Part D enrollees receiving the LIS accounted for about 56 percent ($43.3 million) of the total.

- The number of prescriptions filled by Part D enrollees totaled 1.41 billion, with about 67 percent (944 million) accounted for by PDP enrollees. The 38 percent of enrollees who received the LIS accounted for about 45 percent (629 million) of the total number of prescriptions filled.

- Medicare beneficiaries enrolled in Part D plans fill 4.2 prescriptions at $231 per month on average. PDP enrollees have higher average monthly spending and more prescriptions filled compared with MA–PD plan enrollees.

- The average monthly plan liability for MA–PD enrollees ($111) is considerably lower than that of PDP enrollees ($154), while average monthly OOP spending is similar for enrollees in both types of plans ($37 vs. $41). The average monthly low-income cost sharing subsidy is much lower for MA–PD enrollees ($23) compared with PDP enrollees ($70).

- Average monthly spending per enrollee for an LIS enrollee ($348) is more than double that of a non-LIS enrollee ($163), while the average number of prescriptions filled per month by an LIS enrollee is 5.1 compared with 3.7 for a non-LIS enrollee. LIS enrollees have much lower OOP spending, on average, than non-LIS enrollees ($8 vs. $59). Part D's LIS pays for most of the cost sharing for LIS enrollees, averaging $142 per month.

Chart 10-17. Part D risk scores vary across regions, by plan type and by LIS status, 2010

PDP region	State(s)	Percent enrolled in PDPs vs. MA–PDs	Percent of Part D enrollees receiving LIS	Average risk score (RxHCC)				
				Part D	PDP	MA–PD	LIS	Non-LIS
				Average absolute risk score				
All regions				1.117	1.137	1.083	1.217	1.055
				Average normalized risk score (mean = 1.0)				
1	ME, NH	85%	49%	0.974	0.971	0.925	0.956	0.962
2	CT, MA, RI, VT	69	43	1.009	1.008	1.001	1.007	0.995
3	NY	55	46	1.029	1.055	1.007	1.015	1.019
4	NJ	81	35	1.036	1.038	0.981	1.032	1.045
5	DE, DC, MD	86	41	1.028	1.016	1.025	1.028	1.021
6	PA, WV	56	33	1.008	1.015	1.008	1.009	1.018
7	VA	78	37	1.000	0.993	0.991	1.003	0.999
8	NC	75	43	1.020	1.017	1.008	1.024	1.004
9	SC	77	45	1.026	1.009	1.058	1.011	1.021
10	GA	69	43	1.027	1.025	1.023	1.018	1.020
11	FL	53	35	1.058	1.067	1.060	1.061	1.062
12	AL, TN	65	47	1.047	1.031	1.076	1.033	1.034
13	MI	73	40	1.016	1.033	0.950	1.030	1.002
14	OH	63	36	1.029	1.042	1.009	1.057	1.018
15	IN, KY	80	39	1.013	1.011	0.987	1.016	1.008
16	WI	63	33	0.954	0.968	0.930	0.991	0.945
17	IL	87	38	0.988	0.981	0.949	0.988	0.988
18	MO	69	35	0.999	1.006	0.975	1.023	0.992
19	AR	80	45	0.997	0.985	1.006	0.973	0.998
20	MS	88	54	1.008	0.993	1.022	0.971	1.006
21	LA	65	49	1.021	1.027	1.007	0.996	1.015
22	TX	69	45	1.035	1.031	1.037	1.026	1.022
23	OK	79	38	0.995	0.990	0.977	0.994	0.995
24	KS	85	29	0.959	0.949	0.950	0.977	0.970
25	IA, MN, MT, NE, ND, SD, WY	73	27	0.910	0.909	0.897	0.949	0.914
26	NM	62	39	0.928	0.917	0.949	0.905	0.942
27	CO	49	29	0.918	0.911	0.938	0.942	0.924
28	AZ	45	32	0.964	0.929	1.011	0.963	0.978
29	NV	48	29	0.963	0.962	0.979	0.967	0.980
30	OR, WA	59	31	0.917	0.910	0.933	0.920	0.929
31	ID, UT	56	28	0.914	0.915	0.921	0.932	0.927
32	CA	51	39	0.953	0.964	0.953	0.939	0.960
33	HI	44	29	0.928	0.919	0.952	0.899	0.959
34	AK	99	62	0.916	0.900	0.935	0.886	0.885
	Mean	64	38	1.000	1.000	1.000	1.000	1.000
	Minimum	44	27	0.910	0.900	0.897	0.886	0.885
	Maximum	99	62	1.058	1.067	1.076	1.061	1.062

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), RxHCC (prescription drug hierarchical condition category). Part D risk scores are calculated by CMS using the RxHCC model developed before 2006. Risk scores shown here are not adjusted for LIS or institutionalized status (multipliers) and are normalized, so that the average across Part D enrollees in each group equals 1.0. If a beneficiary was enrolled in both a PDP and an MA–PD plan during the year, that individual was classified in the type of plan with a greater number of months of enrollment.

Source: MedPAC analysis of Medicare enrollment and Risk Adjustment System files from CMS.

(Chart continued next page)

Chart 10-17. Part D risk scores vary across regions, by plan type and by LIS status, 2010 (continued)

- Under Part D, payments to stand-alone PDPs and MA–PD plans are adjusted to account for differences in enrollees' expected costs using the RxHCC model. The RxHCC model uses age, gender, disability status, and medical diagnosis to predict Part D benefit spending. As is true for any risk-adjustment model, the RxHCC model does not explain all variation in future payments. The model may also produce higher scores in areas with high service use because there are more opportunities to make diagnoses in those areas and the RxHCC model uses diagnoses among other factors in its score.

- In 2010, the normalized average risk scores for Part D enrollees varied from 0.91 (Region 25) to 1.058 (Region 11), meaning that average expected costs per enrollee ranged from about 9 percent below the national average to about 5.8 percent above the national average across regions.

- The overall average risk score for PDP enrollees (1.137) is higher than that of MA–PD enrollees (1.083) and is consistently so across all regions (not shown in table), except in Arizona (Region 28), where most (55 percent) Part D enrollees are enrolled in MA–PDs. In contrast, normalized risk scores for both PDP and MA–PD enrollees are similar in most regions, with the difference exceeding 0.05 (5 percentage points) in only three regions: New Jersey (Region 4), Michigan (Region 13), and Arizona (Region 28).

- The overall average risk score for enrollees receiving the LIS (1.217) is higher than that of non-LIS enrollees (1.055) and is consistently so across all regions (not shown in table). In contrast, normalized risk scores for both LIS and non-LIS enrollees are similar in most regions, with the difference exceeding 0.05 (5 percentage points) only in Hawaii (Region 33), where a relatively small share of enrollees receives the LIS (29 percent).

Chart 10-18. Top 15 therapeutic classes of drugs under Part D, by spending and volume, 2010

Top 15 therapeutic classes by spending	Dollars	
	Billions	Percent
Antihyperlipidemics	$6.7	8.6%
Antipsychotics	6.5	8.4
Diabetic therapy	6.2	8.0
Antihypertensive therapy agents	5.1	6.5
Asthma/COPD therapy agents	4.9	6.3
Peptic ulcer therapy	4.1	5.2
Platelet aggregation inhibitors	3.4	4.4
Cognitive disorder therapy (antidementia)	3.2	4.2
Antidepressants	3.1	4.0
Analgesics (narcotic)	3.0	3.9
Antivirals	2.7	3.5
Anticonvulsants	2.2	2.9
Analgesics (anti-inflammatory/ antipyretic, non-narcotic)	1.8	2.3
Calcium & bone metabolism regulators	1.7	2.2
Antibacterial agents	1.5	1.9
Subtotal, top 15 classes	56.2	72.4
Total, all classes	77.7	100.0

Top 15 therapeutic classes by volume	Prescriptions	
	Millions	Percent
Antihypertensive therapy agents	145.6	10.4%
Antihyperlipidemics	136.2	9.7
Beta adrenergic blockers	88.9	6.3
Diabetic therapy	88.2	6.3
Diuretics	77.4	5.5
Antidepressants	76.8	5.5
Peptic ulcer therapy	67.7	4.8
Analgesics (narcotic)	67.2	4.8
Calcium channel blockers	60.3	4.3
Thyroid therapy	49.5	3.5
Antibacterial agents	39.4	2.8
Anticonvulsants	38.6	2.7
Asthma/COPD therapy agents	38.5	2.7
Analgesics (anti-inflammatory/ antipyretic, non-narcotic)	26.5	1.9
Calcium & bone metabolism regulators	25.7	1.8
Subtotal, top 15 classes	1,026.6	73.0
Total, all classes	1,406.0	100.0

Note: COPD (chronic obstructive pulmonary disease). Volume is the number of prescriptions standardized to a 30-day supply. Therapeutic classification based on the First DataBank Enhanced Therapeutic Classification System 1.0. Numbers may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Part D prescription drug event data from CMS.

- In 2010, gross spending on prescription drugs covered by Part D plans totaled $77.7 billion. The top 15 therapeutic classes by spending accounted for about 72 percent of the total.
- About 1.4 billion prescriptions were dispensed in 2010, with the top 15 therapeutic classes by volume accounting for 73 percent of the total.
- Eleven therapeutic classes are among the top 15 based on both spending and volume. Central nervous system agents (antipsychotics, anticonvulsants, and antidepressants) and cardiovascular agents (antihyperlipidemics, antihypertensive therapy agents) dominate the list by spending, each accounting for about one-fifth of the spending, while cardiovascular agents (antihyperlipidemics, antihypertensive therapy agents, beta adrenergic blockers, calcium channel blockers, and diuretics) dominate the list by volume, accounting for nearly 50 percent of the prescriptions in the top 15 therapeutic classes.

Chart 10-19. Generic dispensing rate for the top 15 therapeutic classes, by plan type, 2010

By order of aggregate spending	PDP share of all prescriptions	Generic dispensing rate		
		All	PDPs	MA–PDs
Antihyperlipidemics	63%	65%	60%	72%
Antipsychotics	83	38	38	39
Diabetic therapy	64	61	58	66
Antihypertensive therapy agents	63	78	75	81
Asthma/COPD therapy agents	71	9	10	7
Peptic ulcer therapy	68	77	74	85
Platelet aggregation inhibitors	68	8	8	10
Cognitive disorder therapy (antidementia)	74	5	4	6
Antidepressants	71	80	78	85
Analgesics (narcotic)	72	94	93	95
Antivirals	76	38	34	51
Anticonvulsants	75	85	84	87
Analgesics (anti-inflammatory/ antipyretic, non-narcotic)	66	82	80	86
Calcium & bone metabolism regulators	65	63	60	69
Antibacterial agents	69	89	89	91
All therapeutic classes	67	74	72	77

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), COPD (chronic obstructive pulmonary disease). Shares are calculated as a percent of all prescriptions standardized to a 30-day supply. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System 1.0. Generic dispensing rate is defined as the proportion of generic prescriptions dispensed within a therapeutic class. Part D prescription drug event records are classified as PDP or MA–PD records based on the contract identification on each record.

Source: MedPAC analysis of Medicare Part D prescription drug event data from CMS.

- In 2010, Part D enrollees in stand-alone PDPs accounted for 67 percent of prescriptions dispensed under Part D. PDP enrollees accounted for a disproportionately high share of prescriptions for classes such as antipsychotics, anticonvulsants, and antivirals. Most of the prescriptions in these classes were taken by low-income subsidy (LIS) beneficiaries, of whom about 80 percent are enrolled in PDPs.

- Overall, analgesics (narcotic) have the highest generic dispensing rate (GDR) (94 percent), followed by antibacterial agents (89 percent) and anticonvulsants (85 percent) compared with 74 percent across all therapeutic classes.

- The GDR for PDP enrollees averages 72 percent across all therapeutic classes, compared with 77 percent for MA–PD plan enrollees. Across the 15 therapeutic classes, GDRs for PDP enrollees were generally lower than for MA–PD enrollees with the exception of agents for asthma/chronic obstructive pulmonary disease therapy.

- There were large differences in GDRs for PDPs and MA–PDs. The largest differences were for antihyperlipidemics, peptic ulcer therapy, and antivirals, with between 11 and 17 percentage point differences. Some of the difference in the GDRs reflects the fact that most beneficiaries receiving the LIS are in PDPs. On average, LIS enrollees are less likely to take a generic medication in a given therapeutic class (see Chart 10-20).

Chart 10-20. Generic dispensing rate for the top 15 therapeutic classes, by LIS status, 2010

By order of aggregate spending	LIS share of prescriptions	Generic dispensing rate		
		All	LIS	Non-LIS
Antihyperlipidemics	35%	65%	59%	67%
Antipsychotics	83	38	37	41
Diabetic therapy	48	61	53	68
Antihypertensive therapy agents	36	78	75	79
Asthma/COPD therapy agents	59	9	11	6
Peptic ulcer therapy	51	77	73	82
Platelet aggregation inhibitors	43	8	7	9
Cognitive disorder therapy (antidementia)	52	5	3	6
Antidepressants	53	80	77	84
Analgesics (narcotic)	59	94	92	95
Antivirals	67	38	24	67
Anticonvulsants	64	85	84	87
Analgesics (anti-inflammatory/ antipyretic, non-narcotic)	48	82	82	82
Calcium & bone metabolism regulators	35	63	59	65
Antibacterial agents	44	89	87	91
All therapeutic classes	45	74	71	76

Note: LIS (low-income subsidy), COPD (chronic obstructive pulmonary disease). Shares are calculated as a percent of all prescriptions standardized to a 30-day supply. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification system 1.0. Generic dispensing rate is defined as the proportion of generic prescriptions dispensed within a therapeutic class. Part D prescription drug event (PDE) records are classified as LIS or non-LIS records based on monthly LIS eligibility information in Part D's denominator file. Estimates are sensitive to the method used to classify PDE records as LIS or non-LIS.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

- In 2010, Part D enrollees receiving the LIS accounted for 45 percent of prescriptions dispensed under Part D. In 10 of 15 therapeutic classes ranked by spending, the share of prescriptions dispensed to LIS beneficiaries was greater than 45 percent, and in 3 classes the share was greater than 60 percent.

- The generic dispensing rate (GDR) for non-LIS beneficiaries averages 76 percent across all therapeutic classes, compared with 71 percent for LIS beneficiaries. Across the top 15 therapeutic classes, GDRs for non-LIS beneficiaries are higher than those for LIS beneficiaries in all but two classes (asthma/chronic obstructive pulmonary disease therapy agents and non-narcotic analgesics).

- There are large differences in GDRs across classes between LIS and non-LIS beneficiaries. The largest difference is for antivirals (45 percentage points). Some of the difference in the GDRs for this therapeutic class likely reflects differences in the mix of drugs taken between the two groups.

Web links. Prescription drugs

- Chapters in several of MedPAC's Reports to the Congress provide information on the Medicare Part D program, as does MedPAC's March 2011 Part D Data Book and Payment Basics series.

  http://www.medpac.gov/chapters/Mar12_Ch13.pdf
  http://www.medpac.gov/chapters/Mar11_Ch13.pdf
  http://www.medpac.gov/chapters/Mar10_Ch05.pdf
  http://www.medpac.gov/documents/Mar10_PartDDataBook.pdf
  http://www.medpac.gov/chapters/Mar09_Ch04.pdf
  http://www.medpac.gov/chapters/Mar08_Ch04.pdf
  http://www.medpac.gov/chapters/Mar08_Ch05.pdf
  http://www.medpac.gov/chapters/Jun07_Ch07.pdf
  http://www.medpac.gov/chapters/Mar07_Ch04.pdf
  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch07.pdf
  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch08.pdf
  http://www.medpac.gov/publications/congressional_reports/June05_ch1.pdf
  http://www.medpac.gov/publications/congressional_reports/June04_ch1.pdf
  http://www.medpac.gov/documents/MedPAC_Payment_Basics_11_PartD.pdf

- Analysis of Medicare payment systems and follow-on biologics can be found in MedPAC's June 2009 Report to the Congress.

  http://www.medpac.gov/chapters/Jun09_Ch05.pdf

- Analysis of Medicare spending on Part B drugs can be found in MedPAC's January 2007 and January 2006 Reports to the Congress.

  http://www.medpac.gov/documents/Jan07_PartB_mandated_report.pdf
  http://www.medpac.gov/publications/congressional_reports/Jan06_Oncology_mandated_report.pdf

- A series of Kaiser Family Foundation fact sheet data spotlights provide information on the Medicare Part D benefit.

  http://www.kff.org/medicare/rxdrugbenefits/partddataspotlights.cfm

- CMS information on Part D.

  http://www.cms.gov/PrescriptionDrugCovGenIn/
  http://www.cms.hhs.gov/MCRAdvPartDEnrolData/
  http://www.cms.gov/PrescriptionDrugCovGenIn/06_PerformanceData.asp#TopOfPage
  http://www.cms.gov/PrescriptionDrugCovGenIn/09_ProgramReports.asp